Crater Local Human Rights Committee Meeting
Thursday, July 11, 2013
5:30 PM

Committee Members Present:
Mr. Edward Barlow, Chair
Ms. Jean Grim, Vice Chair
Mr. Carlton Starke
Mr. Steve Pories (Absent)
Mr. Daniel Moore (Absent)
Ms. Sequoya Willis (Absent)

Human Rights Advocate
Taneika Goldman

Crater LHRC Secretary
Ms. Fabri D. Claiborne

Affiliates Present:

Adult Activity Services – James Scott
Benchmark Residential Services – Clarence Dilworth
Dan-Poe-Dil, Inc. – Clarence Dilworth
Happy Home Counseling Services – Quinn Wilson
JC HomeLife – Keith Blom, Rodarneek Om
Low Ground Visions, Inc./Day Support –Chanda Batts Stevenson, Cynthia Batts
New Beginning, Inc. – Marilyn Newby
Phoenix and Peace – Marilyn Newby
Progressive Adult Rehabilitation Center, Inc. – Felecia Daniels
Pryor House – Jeronica Page
Southside Regional Hospital – Inpatient, Outpatient – Sandra McCabe
T'Lab – Janine Johnson
TruCare Homes, LLC – Simone Harris, Shawnda Williams
DePaul Community Resources – Peggy Ball
John Randolph Medical Center – Mark Smallacombe
Live 4 Life, Inc. – Jason Jackson
Visions Family Services, Inc. – Robert Taylor

Affiliates Absent:

Family and Youth Services

I. Call to Order

A quorum being present, Chair Edward Barlow called the Crater Local Human Rights Committee meeting to order at 5:32 PM at Taylor-Starkewood Enterprises 589 S. Crater Road, Petersburg, Virginia.

I. ***Public Comments:***

Issues with the new CHRIS system were discussed. Ms. Goldman supplied numerous suggestions, especially contacting Margaret Walsh when issues arise. Ms. Goldman also handed out Part VII Reporting Requirements to the affiliates.

II. Approval of Minutes

A motion was made and seconded to approve the minutes of the Thursday, April 11, 2013 meeting. Ayes: Carlton Starke, seconded Jean Grim.

III. Advocate's Comments

Ms. Goldman discussed that the Human Rights regulations are in the review/revision process. VOPA as of October 1, 2013 will no longer be funded by the state, but funded by a non-profit and change their name to the Disability Law Center. Ms. Goldman passed out information on restraints and seclusion to affiliates: including requirements about reporting and classification.

IV. Financial Report

Ms. Newby thanked the affiliates for the payment of their LHRC dues.

V. Old Business

VI. New Business

VII. Event Report Statistics

Reports from each provider on events occurring during the reporting period of April 1, 2013 – June 30, 2013

a) **Adult Activity Services** –
No incidents to report

b) **Benchmark Residential Services**
Carson House

On 4/26/13, an individual residing at Carson House, had fallen in his bed room and that he had a small cut on the left side of his head. The decision was made to transport SM to the emergency room at Southside Regional Medical Center to have the injury evaluated by medical personnel. After an investigation, it was concluded that the individual's injury was unintentionally self-inflicted and was not the associated with abuse or neglect.

On 5/2/13 at approximately 7:15 am the Program Director received a call from Residential Counselor and over-night staff at Carson House stating that an individual residing at Carson House, appeared to be disoriented and had difficulty standing and keeping his balance. The decision was made to hold him back from his day support program and transport him to the emergency room for evaluation.

The conclusion reached by this investigation is that SM's emergency room visit was not the result of abuse or neglect by staff.

On 5/7/13 at approximately 7:45 am the Program Director received a call from the Program Director at Metro Area Support Services, stating that an individual residing at Carson House, arrived at the day support that morning with a bruise and swelling over his left eye.

After the necessary investigation the conclusion reached by this investigation is that sometime between 10:00pm on 5/6/13 and 7:40 am on 5/7/13 the client received a blow from a blunt object around the area of his left eye causing a contusion over his left eye. The residential staff on duty does not know how the injury occurred. The residential staff states that he was engaged in household chores in a part of the house which precluded him from providing direct supervision of the client and the other individuals in the home. This lack of supervision occurred in spite of the fact that the client had a recent history of being disoriented in the morning, had sustained a previous injury on that shift/residential staff, and residential staff had been instructed to provide the client close supervision during morning routine. The conclusion of this investigation is that residential staff was neglectful by not providing constant and direct supervision as instructed. The client was seen by the attending physician at the Southside Regional Medical Center emergency room. He was given a CAT scan. It was noted that he had a contusion and he was discharged from the emergency room with a prescription for Ancetaminophen to help relieve pain and reduce fever and a prescription for Ibuprofen to help relieve pain and reduce inflammation. The residential support staff on duty at the time of the incident, has been terminated.

c) **Dan-Poe-Dil**
Wedgewood House
No activity to report

Church Road House
On June 10, 2013 at approximately 8:00 PM the Program Director received a call from the Residential Counselor at Church Road House stating that an individual residing at Church Road House became upset, attacked several of his housemates, turned over furniture, and broke a window with his fist. The Program Director instructed residential staff to notify the client's psychiatrist of the incident. The incident was reported to his attending psychiatrist who admitted RB to the psychiatric ward at John Randolph Medical Center in Hopewell, VA.

There were two staff members on duty at the time.

Following the necessary investigation the client's behavior escalated to the point that he was a danger to himself and others. Residential staff acted appropriately by isolating other individuals to keep them safe until the behavior subsided. There were no injuries requiring medical attention.

On June 10, 2013 at approximately 8:00 PM the Program Director received a call from C.B, Residential Counselor at Church Road House stating that an individual residing at Church Road House became upset while riding on the van and hit one of his peers in the face

There was two staff on duty at the time.

Following the necessary investigation, it was concluded that the Residential staff acted appropriately by getting the van off the road and separating the combatants to prevent injury. There was no evidence to indicate that staff was negligent in their duties.

Fairway House
No activity to report

d) **DePaul Community Resources**

An individual's J-tube became clogged. He was taken to the hospital, admitted and J-tube repaired. The doctors & DCR staff determined no neglect on part of care provider. Doctor's report indicated medical issues with intestines.

Ms. Goldman wanted to clarify for Ms. Ball that on her report she did not reflect the incident as neglect. Ms. Ball is to revise her quarterly report and email to Ms. Goldman by Monday, July 15, 2013.

e) Family and Youth Services
Absent. No Report Submitted.

f) Happy Home Counseling
No activity to report.

Mr. Barlow instructed Happy Homes add more to question number four on how to build up the membership for LHRC

g) JC Homelife
No activity to report.

h) **John Randolph Medical Center** –
Two incidents of seclusion.

Quarterly Review of any Behavioral Plans involving the use of restraint or time out: 1 Client –total of 8 hours seclusion.

A patient assaulted female staff member as she was attempting to pass medications to a female peer. The client was placed in seclusion per physicians order for 4 hours. During this time, the client was monitored every 15 minutes per hospital policy and offered nourishment, toilet, and ADL care (to which he refused) Client remained aggressive and threatening during the time in seclusion and was released upon verbalization of no intentions to harm.

A patient assaulted Male Staff Member. While walking the hallway during rounds, the client approached the staff from behind and proceeded to punch him in the back of the head. The client was escorted by staff to seclusion where he proceeded to threaten staff verbally. The client remained in seclusion for a total of 4 hours until he was able to verbalize no intent to harm. During this time he was offered nourishment, toilet, and ADL care to which he refused and continued to threaten the safety of staff.

i) Lea and Associates – Excused Absence

Intensive In Home
No activity to report

j) **Live 4 Life** –
No activity to report

Received a full license.

k) **Low Ground Visions, Inc**.
Residential Service
Two community complaints

5/15/2013: approx. 1:05 pm. Received a call from Licensing Specialist (Davis) she was responding to a community allegation concerning a client,-
1st. Allegation of weight loss, (not getting enough food).
2nd Individual spine had a usual curvature, which looks susceptive.

Inspector gave suggestion of what needs to be done and to get back with her if needed.
A follow-up with Primary Physician visit and documentation of findings. All parties notified of response and seemed to be satisfied with findings, not founded, physician address both the weight loss, no significant weight loss, supplement order with meals. The reason for curvature of spine, diagnosis with kyphosis, no improvement and no treatment at this time. No appeals requested.

Ms. Goldman noted that if a policy is changed due to a complaint whether founded or unfounded, the LHRC must be informed. This is necessary because the policy could impact other clients being served.

Day Support
On 4/16/2013 Dept. of Social Service Case Worker made an unannounced visit to resident. The reason for the visit was due to receiving a complaint about particular individual not getting enough food, personal items missing, closet had other person clothes. Food in refrigerator and cabinets expired.
On 5/13/2013 Case Manager visited Residential site. The reason was to respond to an alleged allegation of physical abuse to Individual living here (DF). The report states that a staff member hit him with a broom approx. 3 weeks from allegation.

l) New Beginning, Inc.

Day Support

On 5/28/13, an individual was struck in the mouth by her Peer when she tried to take a radio from him that she thought was too loud.

Individuals involved were counseled individually and jointly. Both agreed that there were better options that they individually could have chosen.

Residential

No activity to report.

m) Phoenix-N-Peace, Inc.

Residential

At approximately 2:45 p.m. on April 24, 2013, it was reported an Individual had put lotion all over her face and into her eyes. The Individual was cleaned up (face and eyes) and her blouse was changed after which they had departed for Day Support. The DSP reported her eye was red. The nurse was notified and she went to Day Support to check the Individual. The nurse, after examining the eye determined the Individual needed medical attention. She was seen by the PCP and was diagnosed with Chemical Conjunctivitis. The Individual was prescribed eye drops that were to be administered 4 times and day and was instructed to return to 5 days.

Residential and Day Support were interviewed in an effort to determine what happened. In conclusion the residential staff was neglectful with supervision which enabled the Individual to put lotion all over her fact getting it into her eyes.

Affected Residential Staff received counseling, a write up for improper supervision of the Individual during bathroom use. They will be suspended and upon their return both employees will be retrained in health and safety procedures in the group home and in how to properly supervise the individuals.

At approximately 7:30 p.m. it was brought to the attention of one of the on-call staff that an Individual had eloped without staff's knowledge. That on-call supervisor immediately notified the Quality Assurance Director, the other on-call supervisor and the Executive Director. Shortly thereafter one of the on-call supervisors received a phone call from a DSP stating the Individual had been located in the Blandford community at a convenience store. When approached the Individual willingly boarded the van to return home with the staff. Upon his return home he was immediately checked for bodily injuries. No injuries were detected. He apologized to one of the on-call supervisors and stated he was sorry and would not do it again. He stated he had become irritated because a peer was teasing him about not having money so he left the home out the back door.

The investigation revealed that the staff assigned during that shift did not properly supervise or monitor the individual who had requested some private time. This enabled the individual to leave the premises and be gone long enough to get to the location where he was picked up from, which was a good distance from the home. As a result of this staff neglected the individual because they failed to conduct checks in a timely manner which would have alerted them that he had left sooner than when they were contacted informing them he had been spotted in the community.

The corrective action recommended is disciplinary action in the form of a suspension (one to three days) for the staff members due to inadequate or unsatisfactory work performance. They also received verbal and written counseling regarding this incident. Upon return from suspension both staff will be retrained in proper supervision of individuals.

Day Support

On Sunday, May 12, 2013, at approximately 7:30 p.m., it was brought to our attention as the on- call supervisory team by a Program Director, that an individual at New Haven had eloped without the staff's knowledge. She received a call from the home at approximately 7:18 p.m.

On 5/17/13, after the completion of the verbal interviews and review of written statements, it was concluded that the incident occurred due to the staff not performing visual or verbal checks on the individual in a more timely fashion (namely every ten to fifteen minutes) since he is a documented eloper. The individual was in his room which does not preclude frequent checks in order to assure his safety. Both staff were otherwise engaged with other individuals in the home, but neglected to physically check on this individual.

The investigation revealed that the staff assigned during that shift did not properly supervise or monitor the individual who had requested some private time. This enabled the individual to leave the premises and be gone long enough to get to the location where he was picked up from which was a good distance from the home. As a result of this the staff neglected the individual because they failed to conduct checks in a timely manner which would have alerted them that the individual had left sooner than when they were contacted of him being spotted in the community.

On June 24, 2013 a client informed a staff member he was struck in the face by another person on the van, returning from Day Support

After all interviews were conducted it appears that there is insufficient evidence because based on all of the interviews we are unable to determine if the incident really occurred because there were no witnesses and the individual that the victim stated hit him is non-verbal and did not indicate whether he hit the individual or not. No one on the vehicle witnessed any type of behavior or incident that would have resulted in the injury that was sustained.

In order for another situation to occur the seating arrangement has been changed on the van where. The individual will now sit up front with the driver and he has also been encouraged to inform staff immediately whenever something happens to him on the van so it can be taken care of right away.

n) **Progressive Adult Rehabilitation Center, Inc. (P.A.R.C.)** –

P.A.R.C Osage House

On 5/15/13- An individual received the wrong medication as a result of staff error. Poison control was contacted. Poison control reported that the individual might become tired since medications that individual received in error were the same medication that was the individual was already taking, but in a higher dosage. Poison control reported that staff should monitor individual, but there were no recommendations to transport to the individual to the hospital or follow up with primary care physician. Individual did not suffer any ill effects as a result of the incident; however, internal investigation revealed that staff was using her cell phone while attempting to pass medications to the individuals, which resulted in the error. Staff who made the error was terminated.

On 6/17/2013- Staff reported that individual had an unexplained bruise on the left side of stomach and abrasion on left shoulder. Due to functioning level the individual is unable to provide any information. Due individual's medical history and nature of the bruise and abrasion, the individual was examined in the primary physician's office. The internal investigation revealed that one of nurses on duty had knowledge of the individual's injuries, but failed to report the incident and take the appropriate steps to make sure that individual received medical care. The nurse in question immediately resigned and left the agency during the initial stage of the investigation. The nurse's actions constituted "Neglect" and as a result the agency will conduct additional training with all staff on Neglect.

P.A.R.C Day Support

No activity to report.

P.A.R.C Supported Living Services
No Activity or Changes to Report

o) **Pryor House**
No activity to report

p) **Southside Regional Medical Center, Inpatient Services**
Each incident of restraints and seclusions were carefully monitored by a physician to ensure their safety and no harm to staff members.

There were six emergency restraints and one emergency seclusion.

q) **Southside Regional Medical Center Outpatient Services**
No activity or changes to report.

r) **T'LAB, Inc**.
No activity or changes to report.

s) TruCare Homes, LLC.
On Monday May 20, 2013, Client #1 and A DSP were arriving home from a community outing and Client #1 asked if they can take a walk in the neighborhood before going inside the house. The DSP accompanied Client #1 on the walk and then Client #1 started to talk about his father and using profanity stating "he hopes his father dies, and if his surgery doesn't go well, he hopes he can die with him". Client #1 began to run down the street away from the DSP and ran across a neighbor's front yard, and stood at the corner of their lawn, as the DSP verbally redirected him off the lawn. Client #1 started to cry and apologized for running away from the DSP, and stated that he is just upset because his father has not called him to give him an update about his surgery. The DSP continued to redirect Client #1 and calm him down back to the house. Upon arrival to the home, the cops were standing on the deck and asked Client #1, why he went on someone's property. Client #1 apologized and stated he would not do it again and began to walk in the house crying, and expressing he doesn't want to go to jail, and he won't do it again. The Prince George Police left the premises.

Trucare Homes - Continued

On Monday, June 17, 2013, Client #2 began to display negative behavior by yelling and cursing at the DSP's on duty. Client #2 started to bang on the walls and his bedroom door hard with force to place holes in the door, in which he did. Prince George Police was riding by patrolling the area and saw Client #2 and one of the DSP's outside but Client #2 was yelling and using profanity and the Officer stopped to ask if everything was alright, and Client #2 started to yell and use profanity, stating to the Officer that he didn't steal the food at Day Support and the lady was lying on him. The Officer called another patrol car because Client #2 stated he wanted to hurt himself. The DSP escorted Client #2 back into the home and he calmed down. The Prince George County police other cop car arrived by then and spoke to Client #2, but he was calm after the DSP's spoke to him about his behavior earlier at Day Support.

TruCare requested and was granted the affiliation of a second ID Adult group home located at 4203 Mcilwaine Drive, North Dinwoodie

t) <u>Visions Family Services</u> -

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<u>Day Support</u>
There was an issue of neglect (peer to peer)
<u>Intensive In Home</u>
No activity or changes to report.

<u>Residential</u>
On 4/28/2013 a resident stated to a staff member they obtained medication from the closet and took some pills. She also stated she called 911. After the arrival of the ambulance, fire department and police, the resident was transported to Southside Regional Medical Center. After an investigation, there was evidence of neglect. The staff member was given a written notice for failure to follow a supervisor's instruction, perform assigned work or comply with established written policies. The staff member is also undergoing extensive orientation training.

On 5/15/2013 a resident became physically aggressive towards a staff member. The staff was the only staff on duty, due to another calling in sick. Upon investigating there was evident to support neglect due to not having sufficient staff on duty.

On 5/18/2013 two female residents became aggressive with one another. Staff was able to intervene and calm them down using sign language. One female still went after the other with physical altercation. Staffing issues were not contributed in the altercation and following the investigation there was no evidence of abuse/neglect.

<u>Therapeutic Day Treatment</u>
No Activity to Report.

A motion was made by Cartlon Starke to approve second quarter reports with the exception of to defer Family and Youth Services and Visions – Residential (due to changes on report) until the October meeting and seconded by Jean Grim.

VIII. Announcements / Updates (Chairperson's Closing Comments)

The next regular scheduled meeting will be held Thursday, October 10, 2013, 5:30 PM at Starkewood Counseling Services, 589 S. Crater Road, Petersburg, VA.

Thank you to Carlton Starke for providing the meeting location.

Pryor House will provide refreshments for the next LHRC.

IX. Closed Session

A motion was made and passed at 7:15 PM that the Local Human Rights Committee go into Closed Session pursuant to the Virginia Code 2.2-3711-A.15 for the protection of the privacy of individuals, their records in personal matters not related to public business . Ayes Carlton Starke, Jean Grim .

A motion was made to reconvene back to open session. Ayes Jean Grim, Carlton Starke.

Outside of closed session motions passed and votes held for acceptance of medical/protective devices- Seatbelt for individual at PARC and Helmet for individual at Phoenix-N-Peace.

X. Other Actions

None

XI. ***Adjournment***

There being no further business, the meeting was adjourned at 7:40 PM.

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Edward Barlow, Chair (Date)

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